HEAD OF HOUSHOLD POST-EXPOSURE PROPHYLAXIS REGISTRATION FORM

Instructions:			
Enter the name and date of birth of each person for whom you are picking up medications. Include estimated weight (in pounds) for all children less than 9 years of age. ** List your name first ** **Continue on back if needed**		Does the person listed have any of the following conditions: - Pregnant / Breast Feeding - Seizures - Age less than 9 years old - Drug allergy to: Doxycycline or Tetracycline *Circle below for each person*	TENNESSEE HEALTH *Staff Section* *Please circle the medication to be dispensed.*
1	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin* *SNS Medication Label Here*
2	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin* *SNS Medication Label Here*
3	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin* *SNS Medication Label Here*
4	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin* *SNS Medication Label Here*
5	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin* *SNS Medication Label Here*
6	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin* *SNS Medication Label Here*

Enter your current address and contact information:

Address:_____

City:_____ State:_____ Zip Code:_____

Contact Phone Numbers

Home: ( )

Mobile: ( )

Work: ( )

☐ I am picking up medications for myself. I agree to take them as prescribed.

☐ I am picking up medications for others in my household. I am authorized to sign for these people, and I agree to provide the medications and instructions to all of them.

Signature_____Date:_____

****WARNING****

The medications you are picking up today may cause side effects, especially if taken with other medications (either prescription or over-the-counter). ***Talk to your health care provider if you or anyone in your household is taking other medications.***

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12	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
13	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
14	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*
15	Name *(Last, First)*: Date of Birth: Weight if under 9 years old:	YES / NO	*Doxycycline* *Ciprofloxacin* *Amoxicillin*	*SNS Medication Label Here*